

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11241 CERTIFICATE OF DEATH

11225

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 4 mo. 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 1345 Randolph St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last ADAMS			4. DATE OF DEATH Month November Day 28 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1889		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Stephen D. Adams			14. MOTHER'S MAIDEN NAME Annie E. Walter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-12-3113		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of stomach with wide-spread metastasis to the upper abdomen DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, moderate - unknown					INTERVAL BETWEEN ONSET AND DEATH 7-10 days unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. 1. Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from July 25 , 19 56 , to November 28 , 19 56 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Joseph Grasperger			M.D. VAH, Perry Point, Md. 11-29-56		
PHYSICIAN'S NAME (Type) J. C. GRASBERGER			Acting Director, Professional Services		
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 11-29-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
				22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son			ADDRESS Wayre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 11-30-56
					24b. REGISTRAR'S SIGNATURE Doreen E. Dougherty

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

115-17

Page One of Two

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. RACE [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. OCCUPATION [REDACTED]		9. CAUSE OF DEATH [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF NEXT OF KIN [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF REGISTRAR [REDACTED]	
16. SIGNATURE OF CLERK [REDACTED]		17. SIGNATURE OF CHIEF CLERK [REDACTED]		18. SIGNATURE OF ASSISTANT CLERK [REDACTED]	
19. SIGNATURE OF DEPUTY CLERK [REDACTED]		20. SIGNATURE OF CLERK IN CHARGE [REDACTED]		21. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
22. SIGNATURE OF CLERK IN CHARGE [REDACTED]		23. SIGNATURE OF CLERK IN CHARGE [REDACTED]		24. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
25. SIGNATURE OF CLERK IN CHARGE [REDACTED]		26. SIGNATURE OF CLERK IN CHARGE [REDACTED]		27. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
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34. SIGNATURE OF CLERK IN CHARGE [REDACTED]		35. SIGNATURE OF CLERK IN CHARGE [REDACTED]		36. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
37. SIGNATURE OF CLERK IN CHARGE [REDACTED]		38. SIGNATURE OF CLERK IN CHARGE [REDACTED]		39. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
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49. SIGNATURE OF CLERK IN CHARGE [REDACTED]		50. SIGNATURE OF CLERK IN CHARGE [REDACTED]		51. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
52. SIGNATURE OF CLERK IN CHARGE [REDACTED]		53. SIGNATURE OF CLERK IN CHARGE [REDACTED]		54. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
55. SIGNATURE OF CLERK IN CHARGE [REDACTED]		56. SIGNATURE OF CLERK IN CHARGE [REDACTED]		57. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
58. SIGNATURE OF CLERK IN CHARGE [REDACTED]		59. SIGNATURE OF CLERK IN CHARGE [REDACTED]		60. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
61. SIGNATURE OF CLERK IN CHARGE [REDACTED]		62. SIGNATURE OF CLERK IN CHARGE [REDACTED]		63. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
64. SIGNATURE OF CLERK IN CHARGE [REDACTED]		65. SIGNATURE OF CLERK IN CHARGE [REDACTED]		66. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
67. SIGNATURE OF CLERK IN CHARGE [REDACTED]		68. SIGNATURE OF CLERK IN CHARGE [REDACTED]		69. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
70. SIGNATURE OF CLERK IN CHARGE [REDACTED]		71. SIGNATURE OF CLERK IN CHARGE [REDACTED]		72. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
73. SIGNATURE OF CLERK IN CHARGE [REDACTED]		74. SIGNATURE OF CLERK IN CHARGE [REDACTED]		75. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
76. SIGNATURE OF CLERK IN CHARGE [REDACTED]		77. SIGNATURE OF CLERK IN CHARGE [REDACTED]		78. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
79. SIGNATURE OF CLERK IN CHARGE [REDACTED]		80. SIGNATURE OF CLERK IN CHARGE [REDACTED]		81. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
82. SIGNATURE OF CLERK IN CHARGE [REDACTED]		83. SIGNATURE OF CLERK IN CHARGE [REDACTED]		84. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
85. SIGNATURE OF CLERK IN CHARGE [REDACTED]		86. SIGNATURE OF CLERK IN CHARGE [REDACTED]		87. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
88. SIGNATURE OF CLERK IN CHARGE [REDACTED]		89. SIGNATURE OF CLERK IN CHARGE [REDACTED]		90. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
91. SIGNATURE OF CLERK IN CHARGE [REDACTED]		92. SIGNATURE OF CLERK IN CHARGE [REDACTED]		93. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
94. SIGNATURE OF CLERK IN CHARGE [REDACTED]		95. SIGNATURE OF CLERK IN CHARGE [REDACTED]		96. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
97. SIGNATURE OF CLERK IN CHARGE [REDACTED]		98. SIGNATURE OF CLERK IN CHARGE [REDACTED]		99. SIGNATURE OF CLERK IN CHARGE [REDACTED]	
100. SIGNATURE OF CLERK IN CHARGE [REDACTED]		101. SIGNATURE OF CLERK IN CHARGE [REDACTED]		102. SIGNATURE OF CLERK IN CHARGE [REDACTED]	

BUREAU V. 3

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11242 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville				c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville 52 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Ave.				d. STREET ADDRESS Aikin Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Estella May Bailey				4. DATE OF DEATH Month Day Year NOV- 20 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1885	
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kennard Riley				14. MOTHER'S MAIDEN NAME Elizabeth Cruikshank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address George W. Bailey, Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Chronic Myocarditis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis - (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11:30 P.M. 1956 Nov-20, 1956 that I last saw the deceased alive on Nov-20, 1956, and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence I. Benson				DATE SIGNED 11-20-56			
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.				ADDRESS Port Deposit, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-23-1956		22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Leva Patterson				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 11-21-56	
				24b. REGISTRAR'S SIGNATURE Irene E. Daugherty			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 26 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

11243 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11227

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D.</u>		c. LENGTH OF STAY IN 1b <u>All life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.D.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Union Hospital</u>			d. STREET ADDRESS <u>Cherry Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Passmore</u> Last <u>Barnett</u>			4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>19 56</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contract work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Andrew Barnett</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Bowlsby</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>201-09-6961</u>		17. INFORMANT <u>William S. Barnett, Elkton R.D.4, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>R. C. Dodson</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Oxford, Pennsylvania</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>			ADDRESS <u>103 Stockton St., Elkton Maryland</u>		
24a. REC'D BY REGISTRAR <u>11/7/56</u>			24b. REGISTRAR'S SIGNATURE <u>FR Trager</u>		

BUREAU V. S.

1956 14 10K

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11228

11244

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lyndora, Pa.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 63 Brendenville	
3. NAME OF DECEASED (Type or print) JULIA F. BENNETT		4. DATE OF DEATH Month November Day 2 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-16-22
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Butler, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW11	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Convulsive disorder DUE TO (c) Prefrontal Lobotomy		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-5- , 19 48 , to 11-2- , 19 56 , and that death occurred at 6:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William M. Harris M.D.			
PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS, M.D. Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-3-56	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON, Harry de Grace, Md.		24a. REC'D BY REGISTRAR DATE 11-3-56	
24b. REGISTRAR'S SIGNATURE Irene E. Langharty			

11232 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecil Elkton				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS North East Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Mary Alice Biermiester				4. DATE OF DEATH Month Day Year November 28 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12, 1884		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Whitehead				14. MOTHER'S MAIDEN NAME Zillah Benjamin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 159-20-8099		17. INFORMANT Amos Whitehead Address North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Month, Day, Year Hour a. m. - p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) -		(County) (State)	
21. I certify that I attended the deceased from 28 Nov., 19 56 , to 28 Nov., 19 56 , that I last saw the deceased alive on 28 Nov., 19 56 , and that death occurred at 11 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East Rd DATE SIGNED 30 Nov '56							
ACTUAL SIGNATURE Klaus H. Huebner		M.D. North East Rd		DATE SIGNED 30 Nov '56			
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-1-1956	22c. NAME OF CEMETERY OR CREMATORY Bay View Methodist		22d. LOCATION (City, town, or county) North East R.d. Cecil, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE Dec 1		24b. REGISTRAR'S SIGNATURE JR Frazer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

11245 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 88 N. Main St				d. STREET ADDRESS 88 N. Main St.			
3. NAME OF DECEASED (Type or print) Sarah Elizabeth Campbell				4. DATE OF DEATH Month 11 Day 9 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1861	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel J. Fisher				14. MOTHER'S MAIDEN NAME Griscilla Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs Viola Tarbert, Perryville, Md. Rural			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Generalized DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10-15, 1956, to 11-9, 1956, that I last saw the deceased alive on 11-9, 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE G. H. Richards Jr., M.D.				ADDRESS (Street, city or town, state) Perryville, Md.			
DATE SIGNED 11/12/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-1956		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 11-12-56	
				24b. REGISTRAR'S SIGNATURE Gene E. Dougherty			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO REGISTRAR OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be examined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G207 11-30-56 et

11245

CERTIFICATE OF DEATH

11231

96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Westmoreland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 25yrs8mos26days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vandergrift 75 x -3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 517 Longfellow Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Vito DONGIOVANNI		4. DATE OF DEATH Month November Day 17 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-89 June 4, 1898
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I	
16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pylonephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Months 20 Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis, bilateral		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) VA		(County) (State)	
21. I certify that I attended the deceased from Feb. 22, 1930 to November 17, 1956 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Grasherger M.D.		ADDRESS (Street, city or town, state) Perry Point, VA Hospital Md	
DATE SIGNED 11/17/56			
PHYSICIAN'S NAME (Type) JOSEPH GRASHERGER, M.D., ACTING DIRECTOR, PROFESSIONAL SERVICES			
22a. CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-18-56	22c. NAME OF CEMETERY OR CREMATORY Unknown
22d. LOCATION (City, town, or county) Vandergrif, Pennsylvania		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre De Grace, Md.	
24a. REC'D BY REGISTRAR 11-19-56		24b. REGISTRAR'S SIGNATURE Jane E. Dougherty	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11247

CERTIFICATE OF DEATH

11232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Main St			
d. STREET ADDRESS S. Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Philip Duke				4. DATE OF DEATH Month Day Year 11 23 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1877	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Duke				14. MOTHER'S MAIDEN NAME Ellen Connors			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 218-05-7202		17. INFORMANT Address Mrs Ralph Winchester, Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1948 to Nov 33, 1956 , that I last saw the deceased alive on Nov. 33, 1956 , and that death occurred at 4:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G.H. Richards Jr. M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Port Deposit, Md. 11-25-56			
PHYSICIAN'S NAME (Type) G.H. Richards Jr. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-1956		22c. NAME OF CEMETERY OR CREMATORY Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 11-25-56	
				24b. REGISTRAR'S SIGNATURE Gene E. Langharty			

CERTIFICATE OF DEATH

THE STATE OF MARYLAND

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
JAMES M. JONES		Male		45		White		1956		Home		10:30 PM		Heart Disease		Natural		J. M. Jones		J. M. Jones		J. M. Jones	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. DATE OF MARRIAGE		16. OCCUPATION		17. EDUCATION		18. PREVIOUS ILLNESS		19. PREVIOUS SURGERY		20. PREVIOUS TRAUMA		21. PREVIOUS DRUGS		22. PREVIOUS ALCOHOL		23. PREVIOUS TOBACCO		24. PREVIOUS OTHER	
Maryland		1911		1935		Teacher		High School		None		None		None		None		None		None		None	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF SURVIVOR		28. SIGNATURE OF SURVIVOR		29. SIGNATURE OF SURVIVOR		30. SIGNATURE OF SURVIVOR		31. SIGNATURE OF SURVIVOR		32. SIGNATURE OF SURVIVOR		33. SIGNATURE OF SURVIVOR		34. SIGNATURE OF SURVIVOR		35. SIGNATURE OF SURVIVOR		36. SIGNATURE OF SURVIVOR	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11248 CERTIFICATE OF DEATH

11233

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 14 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 47 Hollingsworth Manor	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle M. Last GAVIN		4. DATE OF DEATH Month November Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1905
9. AGE (In years lost birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Gavin		14. MOTHER'S MAIDEN NAME Fannie Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Hospital Records, VAH, Perry Point, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis diffuse, due to extravasated contents 540.0 DUE TO of viscera, post-operative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastric resection (c) Gastric ulcer benign		INTERVAL BETWEEN ONSET AND DEATH 2-3 days 10-29-56 unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatorenal syndrome - 24 hrs. Rheumatic valvular heart disease - unk.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) VA		(County) (State)	
21. I certify that I attended the deceased from October 18, 1956 to November 1, 1956 , and that death occurred at 4:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. A. Oppler		M.D. V.A. Hospital, Perry Point, Md. 11-1-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-1-56	22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town, or county) Arlington, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Perrington & Son		ADDRESS de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 11-3-56		24b. REGISTRAR'S SIGNATURE Gene E. Langherty	

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11233

CERTIFICATE OF DEATH

11234

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1122 Ave. C.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Luyex Last Haff				4. DATE OF DEATH Month 11 Day 26 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-1876		9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Steven I. Haff				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Arthur C. Kolhoff, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Anemia - Cause unknown DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypersplenism (c) Fall at Home - L hip fracture						INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs. 3-4 yrs. 38 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intertrochanteric Fracture L. hip						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 5 o. m. Oct 19 19 56 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) Perry Point		(County) Cecil (State) Md.	
21. I certify that I attended the deceased from 10/19 , 19 56 , to 11/26 , 19 56 , that I last saw the deceased alive on 11/25 , 19 56 , and that death occurred at 6 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Sadowsky				M.D. Perryville		DATE SIGNED 11/26/56	
PHYSICIAN'S NAME (Type) W. H. SADOWSKY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-1956		22c. NAME OF CEMETERY OR CREMATORY Amityville Cemetery		22d. LOCATION (City, town, or county) (State) Amityville, New York.	
23. FUNERAL DIRECTOR'S SIGNATURE Veera Patterson & Son,				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 11/27/56	
				24b. REGISTRAR'S SIGNATURE JR Frazier			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Page One of Two

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF BIRTH [Illegible]</p>		<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. RACE [Illegible]</p>	
<p>7. DATE OF DEATH [Illegible]</p>		<p>8. PLACE OF DEATH [Illegible]</p>		<p>9. CAUSE OF DEATH [Illegible]</p>	
<p>10. MANNER OF DEATH [Illegible]</p>		<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>14. SIGNATURE OF CORONER [Illegible]</p>		<p>15. SIGNATURE OF REGISTRAR [Illegible]</p>	

BUREAU V. S.

NOV 29 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11234 CERTIFICATE OF DEATH

11235

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Elkton, 162 Hollingsworth Manor			
3. NAME OF DECEASED (Type or print) Thomas M. HARRINGTON				4. DATE OF DEATH 11 17 19 56			
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1885		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Rail Road		11. BIRTHPLACE (State or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas M. Harrington				14. MOTHER'S MAIDEN NAME Melvina Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 709-09-8500		17. INFORMANT 162 Hollingsworth Manor Mrs. Josephine Harrington, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated duodenal ulcer 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with Atrial fibrillation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 11/16 , 19 56 , to 11/17 , 19 56 , that I last saw the deceased alive on 11/17/56 , 19 56 , and that death occurred at 4:00 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer				ADDRESS (Street, city or town, state) 138 W. MAIN ST		DATE SIGNED 11/17/56	
PHYSICIAN'S NAME (Type) John A. Fischer, MD				ELKTON, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-1956		22c. NAME OF CEMETERY OR CREMATORY Gracelawn Memo. Pk.		22d. LOCATION (City, town, or county) (State) duPont Hwy Frrhrst, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poffin				ADDRESS 259 E. Main St Elkton Md		24a. REC'D BY REGISTRAR W. A. Lusby	
				DATE 11/20/56		24b. REGISTRAR'S SIGNATURE FR Trager	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF CHURCH OFFICIAL		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF HEALTH DEPARTMENT		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF CITY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF FEDERAL CLERK		27. SIGNATURE OF POSTAL CLERK	
28. SIGNATURE OF MARINE CLERK		29. SIGNATURE OF AIR FORCE CLERK		30. SIGNATURE OF NAVY CLERK	
31. SIGNATURE OF ARMY CLERK		32. SIGNATURE OF AIR FORCE CLERK		33. SIGNATURE OF NAVY CLERK	
34. SIGNATURE OF ARMY CLERK		35. SIGNATURE OF AIR FORCE CLERK		36. SIGNATURE OF NAVY CLERK	
37. SIGNATURE OF ARMY CLERK		38. SIGNATURE OF AIR FORCE CLERK		39. SIGNATURE OF NAVY CLERK	
40. SIGNATURE OF ARMY CLERK		41. SIGNATURE OF AIR FORCE CLERK		42. SIGNATURE OF NAVY CLERK	
43. SIGNATURE OF ARMY CLERK		44. SIGNATURE OF AIR FORCE CLERK		45. SIGNATURE OF NAVY CLERK	
46. SIGNATURE OF ARMY CLERK		47. SIGNATURE OF AIR FORCE CLERK		48. SIGNATURE OF NAVY CLERK	
49. SIGNATURE OF ARMY CLERK		50. SIGNATURE OF AIR FORCE CLERK		51. SIGNATURE OF NAVY CLERK	
52. SIGNATURE OF ARMY CLERK		53. SIGNATURE OF AIR FORCE CLERK		54. SIGNATURE OF NAVY CLERK	
55. SIGNATURE OF ARMY CLERK		56. SIGNATURE OF AIR FORCE CLERK		57. SIGNATURE OF NAVY CLERK	
58. SIGNATURE OF ARMY CLERK		59. SIGNATURE OF AIR FORCE CLERK		60. SIGNATURE OF NAVY CLERK	
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64. SIGNATURE OF ARMY CLERK		65. SIGNATURE OF AIR FORCE CLERK		66. SIGNATURE OF NAVY CLERK	
67. SIGNATURE OF ARMY CLERK		68. SIGNATURE OF AIR FORCE CLERK		69. SIGNATURE OF NAVY CLERK	
70. SIGNATURE OF ARMY CLERK		71. SIGNATURE OF AIR FORCE CLERK		72. SIGNATURE OF NAVY CLERK	
73. SIGNATURE OF ARMY CLERK		74. SIGNATURE OF AIR FORCE CLERK		75. SIGNATURE OF NAVY CLERK	
76. SIGNATURE OF ARMY CLERK		77. SIGNATURE OF AIR FORCE CLERK		78. SIGNATURE OF NAVY CLERK	
79. SIGNATURE OF ARMY CLERK		80. SIGNATURE OF AIR FORCE CLERK		81. SIGNATURE OF NAVY CLERK	
82. SIGNATURE OF ARMY CLERK		83. SIGNATURE OF AIR FORCE CLERK		84. SIGNATURE OF NAVY CLERK	
85. SIGNATURE OF ARMY CLERK		86. SIGNATURE OF AIR FORCE CLERK		87. SIGNATURE OF NAVY CLERK	
88. SIGNATURE OF ARMY CLERK		89. SIGNATURE OF AIR FORCE CLERK		90. SIGNATURE OF NAVY CLERK	
91. SIGNATURE OF ARMY CLERK		92. SIGNATURE OF AIR FORCE CLERK		93. SIGNATURE OF NAVY CLERK	
94. SIGNATURE OF ARMY CLERK		95. SIGNATURE OF AIR FORCE CLERK		96. SIGNATURE OF NAVY CLERK	
97. SIGNATURE OF ARMY CLERK		98. SIGNATURE OF AIR FORCE CLERK		99. SIGNATURE OF NAVY CLERK	
100. SIGNATURE OF ARMY CLERK		101. SIGNATURE OF AIR FORCE CLERK		102. SIGNATURE OF NAVY CLERK	

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NOV 21 1955
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11236

11249 CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. NAVAL HOSPITAL, BAINBRIDGE, MD.		d. STREET ADDRESS R. F. D. #1	
3. NAME OF DECEASED (Type or print) First LULA Middle MAE Last HAYDEN		4. DATE OF DEATH Month NOVEMBER Day 11 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 11, 1956
9. AGE (In years last birthday) yrs. 22		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME James A. HAYDEN		14. MOTHER'S MAIDEN NAME Virginia Frances SCHATUNG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #7620 Asphyxia, Fetal 762.0 DUE TO Due to Prolapse of Umbilical Cord Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) During Breech Presentation DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH 22 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOVEMBER 11, 1956 , to NOVEMBER 11, 1956 , that I last saw the deceased alive on NOVEMBER 11, 1956 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. Michael Sheehan MD		ADDRESS (Street, city or town, state) U. S. NAVAL HOSPITAL, BAINBRIDGE, MARYLAND	
DATE SIGNED 11-11-56			
PHYSICIAN'S NAME (Type) F. Michael SHEEHAN M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-56	
22c. NAME OF CEMETERY OR CREMATORY Not Nottingham		22d. LOCATION (City, town, or county) (State) Calaca Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson, Son, Perryville, Md		24a. REC'D BY REGISTRAR Dorothy B. Bunkle	
ADDRESS 2051293XV5		DATE 11-13-56	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. NAME OF FUNERAL HOME		14. NAME OF BURIAL PLACE		15. NAME OF CEMETERY	
16. NAME OF WITNESS		17. NAME OF WITNESS		18. NAME OF WITNESS		19. NAME OF WITNESS		20. NAME OF WITNESS	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS		25. NAME OF WITNESS	
26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS	
36. NAME OF WITNESS		37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS	
46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS		49. NAME OF WITNESS		50. NAME OF WITNESS	
51. NAME OF WITNESS		52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS	
56. NAME OF WITNESS		57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS		65. NAME OF WITNESS	
66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS		70. NAME OF WITNESS	
71. NAME OF WITNESS		72. NAME OF WITNESS		73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS	
76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS		85. NAME OF WITNESS	
86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS		89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS	
96. NAME OF WITNESS		97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS	

BUREAU V. 3

NOV 16 1956

RECEIVED

11250 CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nottingham, Pa.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) WILLARD L. HEADLY		4. DATE OF DEATH Month November Day 2 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamship Captain		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Willard L. Headly, Sr.		14. MOTHER'S MAIDEN NAME Charlotte Wardle Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 427-36-3818	
17. INFORMANT Mrs. Ethel Booth Headly, R.D. 3		Address Elkton Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage DUE TO (c) Cardiovascular renal		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/2/56 , to 11/2/56 , that I last saw the deceased alive on 11/2/56 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED 11/3/56			
ACTUAL SIGNATURE J. Herbert Bates M.D.		DATE SIGNED 11/3/56	
PHYSICIAN'S NAME (Type) J. Herbert Bates		M.D. 230 East Main Street, Elkton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth Cem	22d. LOCATION (City, town, or county) (State) R. D. Elkton Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		24. REC'D BY REGISTRAR NOV 9 1956	
ADDRESS 103 Stockton St, Elkton, Md.		24b. REGISTRAR'S SIGNATURE Louise H. Hightower	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 9 1956

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11251

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. LENGTH OF STAY IN 1b <u>7 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				d. STREET ADDRESS <u>North East, Cecil</u>			
3. NAME OF DECEASED (Type or print) First <u>Lola</u> Middle <u>Clementine</u> Last <u>Holbrook</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Willes County No. Car. USA</u>		11. BIRTHPLACE (State or foreign country)			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Cornelius Waddell</u>			
14. MOTHER'S MAIDEN NAME <u>Rosy Smoot</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>42-46-22-4911</u>				17. INFORMANT <u>Husband</u> Address <u>North East R 1 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Aortic Stenosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>5 yrs.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rising Sun, Md</u>	
20f. (City or town) <u>Rising Sun, Md</u>				20g. (County) <u>Cecil</u>		20h. (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>8-28-56</u> 1956 to <u>11/2</u> 1956 that I last saw the deceased alive on <u>11/2</u> 1956, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>			
PHYSICIAN'S NAME (Type) <u>Neil R. Taylor Jr.</u>				DATE SIGNED <u>11/2/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-5-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Cecil Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East Md</u>		24a. REC'D BY REGISTRAR DATE <u>11-3-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Sarah C. Wethermel</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11252 CERTIFICATE OF DEATH

Reg. Dist. No.

11239

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 5010 Cordelia Avenue	
3. NAME OF DECEASED (Type or print) First MORRIS Middle (NMI) Last HORVITZ		4. DATE OF DEATH Month November Day 5 Year 19 56	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1887
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		9b. KIND OF BUSINESS OR INDUSTRY Postal Dept.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY Postal Dept.	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Jennie Yaffa	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Infarction of myocardium due to embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis, severe DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 11, 1951, to November 5, 1956, and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) VAH, Perry Point, Maryland	
PHYSICIAN'S NAME (Type) W. Oppler		DATE SIGNED 11-6-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 11-7-56	
22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		22d. LOCATION (City, town, or county) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc., 2100 Eutaw Place, Baltimore, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

NOV 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11253 CERTIFICATE OF DEATH

11240

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED First Mitchell Middle N. Last Johnson		4. DATE OF DEATH Month November Day 4 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1915
9. AGE (In years lost birthday) yrs. 41		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10b. KIND OF BUSINESS OR INDUSTRY Produce	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Josephine Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-20-9079	
17. INFORMANT Hospital records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, pulmonary, bilateral, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor pulmonale DUE TO (c) Chronic passive congestion of the liver, spleen & the kidneys			
INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. Month VA Day 19 Year 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 2, 1956 to 11-4-56 and that death occurred at 8:31 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Perry Point, Md. DATE SIGNED 11-5-56			
ACTUAL SIGNATURE W. Oppler		PHYSICIAN'S NAME (Type) W. OPPLER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Katie R. Williams		24. REC'D BY REGISTRAR NOV 7 1956	
24b. REGISTRAR'S SIGNATURE Katie R. Williams		24c. REGISTRAR'S SIGNATURE Katie R. Williams	

Katie R. Williams Fun. Home, 321-323 N. Schroeder St.
Katie R. Williams Fun. Home 321-323 N. Schroeder St.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
John Johnson		1956	
AGE		SEX	
45		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTH DATE		BIRTH PLACE	
1911		Maryland	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
Teacher		Heart Disease	
HOSPITAL		DATE OF BURIAL	
St. Mary's Hospital		1956	
BURIAL PLACE		CITY	
St. Mary's Cemetery		Baltimore	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	

BUREAU V. 3

NOV 7 1956

RECEIVED

11251 CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. LENGTH OF STAY IN 1b 16 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last LESTER PHILLIP LAWSON				4. DATE OF DEATH Month Day Year Nov 13 19 56			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-56	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lester Leslie Lawson				14. MOTHER'S MAIDEN NAME Margaret L. Rineholt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MARGARET L. LAWSON, WHITEFORD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FETAL ASPHYXIA 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 20 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-12, 1956, to 11-12, 1956, that I last saw the deceased alive on 11-13, 1956, and that death occurred at 12:12 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. U.S.N. Hospital, Bainbridge, 11-13-56 ACTUAL SIGNATURE [Signature] PHYSICIAN'S NAME (Type) John H. Haskins, Delta, Pa.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-14-56		22c. NAME OF CEMETERY OR CREMATORY ST. MARYS		22d. LOCATION (City, town, or county) (State) RYLESVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS John H. Haskins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE 11-13-56		24b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Earlville R.D.</u>		c. LENGTH OF STAY IN lb <u>25 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Earlville, R.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hacks Point</u>				d. STREET ADDRESS <u>Hacks Point</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Augustus Loveland</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1873</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wiring</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No information</u>				14. MOTHER'S MAIDEN NAME <u>No information</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>222-14-2626</u>		17. INFORMANT Address <u>Verna Loveland, Earlville, R.D. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (a), stating the underlying cause last. (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 17 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>		22d. LOCATION (City, town or county) (State) <u>Earlville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Ballou</u>				24a. REC'D BY REGISTRAR <u>11-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Ralph Bess</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

OV 21 1956

RECEIVED

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11235 CERTIFICATE OF DEATH

11243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 10 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				d. STREET ADDRESS Rural Elkton,			
3. NAME OF DECEASED (Type or print) First Ella Middle Dey Last Lusby				4. DATE OF DEATH Month November Day 28 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 26, 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83		IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William H. Dey				14. MOTHER'S MAIDEN NAME Mary H. Grant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT William A Lusby Address RFD#2 Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Stenosis DUE TO (c) Cardio vascular renal							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years 10 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 28 , 19 56 , to Nov 28 , 19 56 , that I last saw the deceased alive on Nov 28 , 19 56 , and that death occurred at 10:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Herbert Bates M.D.				ADDRESS (Street, city or town, state) Elkton Md DATE SIGNED 11/28/56			
PHYSICIAN'S NAME (Type) J. HERBERT BATES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Phipps ADDRESS Elkton, Md				24a. REC'D BY REGISTRAR 12/4/56		24b. REGISTRAR'S SIGNATURE JR Frazier	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		REMARKS																	
JAMES J. JONES		M		35		JAN 15 1920		NEW YORK		JAN 15 1955		NEW YORK		HEART DISEASE		NATURAL		CLERK		HIGH SCHOOL		CATHOLIC		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED																	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE		FATHER'S SINGLE		MOTHER'S SINGLE		FATHER'S MARRIED		MOTHER'S MARRIED		FATHER'S WIDOWED		MOTHER'S WIDOWED		FATHER'S DIVORCED		MOTHER'S DIVORCED		FATHER'S REMARKS		MOTHER'S REMARKS	
JOHN J. JONES		MARY J. JONES		CLERK		HOUSEWIFE		NEW YORK		NEW YORK		JAN 15 1885		JAN 15 1890		HEART DISEASE		HEART DISEASE		NATURAL		NATURAL		CATHOLIC		CATHOLIC		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED			

BUREAU V. S.

DEC 5 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11244

11253

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Harri Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bainbridge		LENGTH OF STAY (in this place) 10 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore , Baltimore Co. 03X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 3014 Cedar Crest Avenue Baltimore			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) WILLIAM GEORGE MALCZEWSKI				4. DATE OF DEATH (Month) (Day) (Year) Nov 4 19 56			
5. SEX Male	6. COLOR OR RACE Cauc	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) ---	8. DATE OF BIRTH 10-25-56	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES FRANK MALCZEWSKI				14. MOTHER'S MAIDEN NAME MARY ROSELLA REITER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) ---		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS Navy Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>PREMATURITY</u>				INTERVAL BETWEEN ONSET AND DEATH 10 days			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-25-19 56, to 11-4-19 56, that I last saw the deceased alive on 11-4-19 56, and that death occurred at 11:34P.M. from the causes and on the date stated above.							
SIGNATURE Albert J. Biese				ADDRESS (Street, city, town, state) ALBERT J. BIESE, LT MC USNR, M.D. USNH, Bainbridge, Md.		DATE SIGNED 11-5-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal & Burial		DATE THEREOF 11-6-1956		NAME OF CEMETERY OR CREMATORY West Pottinghams		LOCATION (City, town, or county) (State) Colora, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Dorothy B. Bramble		25. FUNERAL DIRECTOR'S SIGNATURE Leva Patterson		ADDRESS Brynnville, Md	
DATE 11-5-56							

2051254XVO

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11238 CERTIFICATE OF DEATH

Reg. Dist. No.

11245

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Elkton Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Henry Masemore				4. DATE OF DEATH November 10 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH October 3, 1887 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY C&P Telephone Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeremiah Franklin Masemore				14. MOTHER'S MAIDEN NAME E lizabeth Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-0693		17. INFORMANT Ida Johnston Masemore Address Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 1, 19 54 to Nov. 10, 19 56 , that I last saw the deceased alive on Nov. 10, 19 56 , and that death occurred at 10:42 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				M.D. 233 E. Main St., Elkton, Md. DATE SIGNED 11/10/56			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/56		22c. NAME OF CEMETERY OR CREMATORY Union Chapel Cem.		22d. LOCATION (City, town, or county) (State) Wilna Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Walther Boney				24a. REC'D BY REGISTRAR Elkton, Md.		24b. REGISTRAR'S SIGNATURE JR. Frazer	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11257 CERTIFICATE OF DEATH

11246

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2325 Hartford		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NATHANIEL T. POOLE				4. DATE OF DEATH Month Day Year November 1 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-27-09	
9. AGE (In years lay by day)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wiley Poole		14. MOTHER'S MAIDEN NAME Lula Booze		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) yes WW II			
16. SOCIAL SECURITY NO. 192-10-4983		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning (clinical) 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema & congestion, bilateral, severe (c) Subacute glomerulonephritis							INTERVAL BETWEEN ONSET AND DEATH 10-14 days 3-5 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerosis, general, mild unknown.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. s. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 24, 19 56 to November 1, 19 56 , and that death occurred at 3:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 11-2-56					
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 11-2-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 11-3-56	
				24b. REGISTRAR'S SIGNATURE Inez E. Dougherty			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		White		1910		1956		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Time of Death		Place of Burial		Funeral Home		Burial Date		Burial Place		Burial Name	
Teacher		High School		Married		Hypertension		1955		10:00 PM		Catholic Cemetery		St. John's		1956		St. John's		John Doe	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Cause of Death	
1956		10:00 PM		Home		Heart Disease		Natural		[Signature]		[Signature]		1956		10:00 PM		Home		Heart Disease	

BUREAU V. 2

NOV 2 1956

RECEIVED

11258 CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE PENNA b. COUNTY LANCASTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAINBRIDGE				c. LENGTH OF STAY IN 1b 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STRASBURG 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. NAVAL HOSPITAL				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EVERETT Middle WITMER Last RADCLIFFE				4. DATE OF DEATH Month Nov Day 6 Year 19 56			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-9-22		9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EVERETT MORRIS RADCLIFFE				14. MOTHER'S MAIDEN NAME CORA MYRTLE WITMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) WWII		16. SOCIAL SECURITY NO. ---		17. INFORMANT Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) NEPHROSCLEROSIS DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-10 , 19 56 , to 11-6 , 19 56 , that I last saw the deceased alive on 11-6 , 19 56 , and that death occurred at 9:10AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Matthew J. Ferguson				ADDRESS (Street, city or town, state) USNH, BAINBRIDGE, MARYLAND		DATE SIGNED 11-6-56	
PHYSICIAN'S NAME (Type) MATTHEW J. FERGUSON, LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-6-56	22c. NAME OF CEMETERY OR CREMATORY Quarryville Cemetery		22d. LOCATION (City, town, or county) (State) Quarryville, Penna		
23. FUNERAL DIRECTOR'S SIGNATURE Paul Reynolds				ADDRESS Quarryville, Penna		24a. REC'D BY REGISTRAR DATE 11-6-56	24b. REGISTRAR'S SIGNATURE Dorothy B. Bramble

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		MEDICAL ATTENDANT _____	
NAME OF PHYSICIAN _____		NAME OF CORONER _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____	
NAME OF NEXT OF KIN _____		NAME OF WITNESS _____	
NAME OF REGISTRAR _____		NAME OF CLERK _____	

BUREAU V. 1

NOV 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11259 CERTIFICATE OF DEATH

11248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Milton Rideout		4. DATE OF DEATH Month Year November 23, 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1920
9. AGE (In years last birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Reids Grove, Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Louis Rideout		14. MOTHER'S MAIDEN NAME Nona Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Hospital Records VAH, Perry Point, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess of liver, right lobe, massive, staphylo- 600.0 DUE TO coccus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis, bilateral (c) Chronic nonspecific prostatitis			INTERVAL BETWEEN ONSET AND DEATH 3 to 4 weeks Unknown Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 21, 19 56, to November 23, 19 56, and that death occurred at 2:40 a.m. on November 23, 19 56, and that death was due to the causes stated above.			
ACTUAL SIGNATURE Joseph Gruber		DATE SIGNED VA Hospital, Perry Point, Maryland 11-23-56	
PHYSICIAN'S NAME (Type) J.C. GRASBERGER, M.D. Acting Director Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 26 1956	22c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery	22d. LOCATION (City, town, or county) (State) Rhodesdale Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Trampton Son Federalburg Md		24a. REC'D BY REGISTRAR DATE 11-24-56 24b. REGISTRAR'S SIGNATURE James E. Dougherty	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11249
p2

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Manor Heights 34A Henley Pk. Way		d. STREET ADDRESS Manor Heights, 34A H. PK Way	
3. NAME OF DECEASED (Type or print) Dennis First John Middle Ryan Last		4. DATE OF DEATH Month 11 Day 25 Year 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint. Eng.		10b. KIND OF BUSINESS OR INDUSTRY Repair Eng.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Ryan		14. MOTHER'S MAIDEN NAME Mary Morken	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Noyes World War I		16. SOCIAL SECURITY NO. 521-07-9613	
17. INFORMANT Address Vada Ryan, 2960 Birch 24 Denve r Col.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-1956	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Fort Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE 11-27-56		24b. REGISTRAR'S SIGNATURE Lucene E. Daugherty	

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HENRY		45		M		W		11-20-56		HOME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
1100 E. 10th St.		Carpenter		Heart Disease		Natural		J. H. Smith		11-20-56	
CITY		STATE		CITY		STATE		CITY		STATE	
BALTIMORE		MD		BALTIMORE		MD		BALTIMORE		MD	
CITY		STATE		CITY		STATE		CITY		STATE	
BALTIMORE		MD		BALTIMORE		MD		BALTIMORE		MD	

BUREAU V. 2

NOV 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11250

11237 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 510 Bow Street	
3. NAME OF DECEASED (Type or print) First Emily Middle A. Last SCOTT		4. DATE OF DEATH Month 11 Day 29 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1891 9. AGE (In years lost birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Scott		14. MOTHER'S MAIDEN NAME Sarah Steele	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruben Reynolds		Address Bow St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS 570.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISRUPTION COLONIC SUTURE LINE DUE TO (c) SIGMOID RESECTION FOR GALL STONE ILLUS			INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/16 , 19 56 , to 11/29 , 19 56 , that I last saw the deceased alive on 11/29/56 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 138 W MAIN ST ELKTON, MARYLAND DATE SIGNED			
ACTUAL SIGNATURE John A. Fischer M.D.		DATE SIGNED 12/4/56	
PHYSICIAN'S NAME (Type) John A. Fischer		ELKTON, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 3, 1956	22c. NAME OF CEMETERY OR CREMATORY Head of Christians	22d. LOCATION (City, town, or county) (State) Nr. Newark, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE Henry Pappert ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR 12/4/56	24b. REGISTRAR'S SIGNATURE JR Fraser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11238

CERTIFICATE OF DEATH

11251

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EIKTON				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS RURAL, EIKTON			
3. NAME OF DECEASED (Type or print) ROGER N. Smith				4. DATE OF DEATH November 14 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1956	
9. AGE (In years lost birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME VERNON Smith				14. MOTHER'S MAIDEN NAME KATHLEEN Justice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT VERNON Smith, R.D. 3 EIKTON, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastroenteritis, acute, cause undetermined 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 7 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 14 Nov '56 19 14 Nov 1956, that I last saw the deceased alive on 14 Nov 1956, and that death occurred at 12:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huchner M.D.				ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 14 Nov '56			
PHYSICIAN'S NAME (Type) KLAUS H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 16, 1956		22c. NAME OF CEMETERY OR CREMATORY LESTERS FORK CEMETERY		22d. LOCATION (City, town, or county) (State) Buchanan Co. VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Eikton, Maryland				24a. REC'D BY REGISTRAR 11/16/56		24b. REGISTRAR'S SIGNATURE FR Frazier	

2065223XV5

CERTIFICATE OF DEATH

MD 504-100

<p>1. Name of deceased: <i>VERNA J. BROWN</i></p>		<p>2. Sex: <i>F</i></p>	
<p>3. Date of birth: <i>1/15/1915</i></p>		<p>4. Place of birth: <i>VERMONT</i></p>	
<p>5. Date of death: <i>11/15/1956</i></p>		<p>6. Place of death: <i>VERMONT</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Immediate cause of death: <i>Heart Disease</i></p>	
<p>9. Contributing causes: <i>None</i></p>		<p>10. Manner of death: <i>Natural</i></p>	
<p>11. Signature of physician: <i>[Signature]</i></p>		<p>12. Signature of registrar: <i>[Signature]</i></p>	
<p>13. Date of registration: <i>11/15/1956</i></p>		<p>14. Place of registration: <i>VERMONT</i></p>	

BUREAU V. S.

NOV 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11252

11239 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ethel M Starr				4. DATE OF DEATH Nov. 12 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-7-1890		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Clinton W. Purner				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Helen W. Brown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 161-16-1535		17. INFORMANT Kirk W. Starr		Address North East, Md,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild Cerebral thrombosis. Mild diabetes mellitus. asthmatic bronchitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 21 Oct., 1956, to 12 Nov., 1956, that I last saw the deceased alive on 12 Nov. '56 19, and that death occurred at 3:40 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner				ADDRESS (Street, city or town, state) North East, Md			
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-56		22c. NAME OF CEMETERY OR CREMATORY North East methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE 11/15/56	
						24b. REGISTRAR'S SIGNATURE JH Trager	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11261 CERTIFICATE OF DEATH

Reg. Dist. No.

112532

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural R. D. 4, Elkton, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First HARRY Middle W. Last STRAHORN, Sr.				4. DATE OF DEATH Month November Day 19 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1886	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Strahorn				14. MOTHER'S MAIDEN NAME Anna Pennypacker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-8338		17. INFORMANT Address Daisy Strahorn, (wife) R. D. 4, Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1952 to Nov 19 19 56 , that I last saw the deceased alive on Nov 19 19 56 , and that death occurred at 5:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Hughes Nutter M.D.		ADDRESS (Street, city or town, state) 106 Hammond St Newark, Del		DATE SIGNED 11-20-56			
PHYSICIAN'S NAME (Type) E. HUGHES NUTTER		NEWARK, DEL					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth		22d. LOCATION (City, town, or county) (State) Cecil Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS 103 Stockton St. Elkton, Md		24a. REC'D BY REGISTRAR DATE 11/21/56		24b. REGISTRAR'S SIGNATURE FR Frazee	

BUREAU V. S.

NOV 26 1956

RECEIVED

Item 13:G210 2-14-57L

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil				11262 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland				c. LENGTH OF STAY IN 1b 22 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 23 Prospect Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARTIN Middle J. Last TIERNEY				4. DATE OF DEATH Month November Day 16 Year 1956							
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-93		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not ascertainable				10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Peter Unknown Michael Tierney				14. MOTHER'S MAIDEN NAME Unknown Catherine Curry							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Address Unknown Hospital Records, VAH, Perry Point, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis, severe DUE TO (c) Arteriosclerosis, generalized, severe.								INTERVAL BETWEEN ONSET AND DEATH 4 to 5 days Unknown Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-22 , 19 34 , to 11-16 , 19 56 , that I last saw the deceased alive on 11-16 , 19 56 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE W. Oppler M.D.											
PHYSICIAN'S NAME (Type) W. OPPLER, M. D., Director, Professional Services											
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-16-56		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Beverly, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON, Harry de Grace, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 11/17/56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35 years		Male		White		April 14, 1928		Jackson, Mississippi		Jackson		Mississippi		United States of America	
MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
PLACE OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
CITY OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
STATE OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
COUNTRY OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
PLACE OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
CITY OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
STATE OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
COUNTRY OF DEATH		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	

BUREAU V. R.

NOV 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G206 11-13-56 et

CERTIFICATE OF DEATH

11240

11255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
c. LENGTH OF STAY IN 1b 13 days				d. STREET ADDRESS Church Point			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle L Last WARREN				4. DATE OF DEATH Month November Day 5 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1934	9. AGE (In years lost birthday) 22 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Warren				14. MOTHER'S MAIDEN NAME Henrietta Grenadier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Henrietta Warren North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.3 MAINTENANCE DUE TO Sigmoid polypoid, chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 months (c) 6 months							INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral palsy with spastic quadriplegia and mental deficiency							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/23 , 19 56 , to 11/5 , 19 56 , that I last saw the deceased alive on 11/5 , 19 56 , and that death occurred at 8:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer				ADDRESS (Street, city or town, state) 138 W. Main St. Elkton, Md			
PHYSICIAN'S NAME (Type) John A. Fischer				DATE SIGNED 11/5/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary Ann Episcopal		22d. LOCATION (City, town, or county) (State) North East, Cecil, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Brant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE 11/7/56	
				24b. REGISTRAR'S SIGNATURE J. A. Fischer			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11256

11263 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA. b. COUNTY P.M.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 27			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First ANTHONY Middle T. Last WOODWARD				4. DATE OF DEATH Month November Day 24 Year 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 1, 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 24 Days 19		IF UNDER 24 HRS. Hours 56 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOSEPH WOODWARD				14. MOTHER'S MAIDEN NAME FLORENCE WILLIAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with head injury - unknown							INTERVAL BETWEEN ONSET AND DEATH 5-6 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 3. Month 19 Day 19 Year 1955 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				(County)		(State)	
21. I certify that I attended the deceased from May 6, 1955 , to November 24, 1956 and that death occurred at 8:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 11-26-56							
ACTUAL SIGNATURE Joseph Gruberger				M.D. V.A. Hospital, Perry Point, Md.			
PHYSICIAN'S NAME (Type) J. C. GRASBERGER				Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-26-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Bartholomew ADDRESS Havre DeGrace, Md.				24a. REC'D BY REGISTRAR DATE 11-27-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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